



Guide to Clinical Validation and Documentation Improvement for Coding

Supporting ICD-10-CM and -PCS code assignments with
clinical documentation

2021

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Documentation Improvement Specialist Professional CDIS CDIP coder physician champion advisor and others involved in the CDI must have The book is a compendium of sound clinical knowledge and experience clinical documentation expertise and quality which will help the CDIS CDIP and others maximize their potentials in performing their core duties Whether you are a new CDIS trying to learn CDI or an experienced CDIS hoping to stay current with CDI world or involved in the CDI this book will be very valuable to you Remember accurate and quality documentation is a reflection of great patient care If it wasn't documented and documented accurately it never happened This book clearly explained various query opportunities by Major Disease Classifications MDCs with some sample queries It defines and analyses different disease processes creates CDIS awareness and what to look for under various MDCs ICD 10 CM PCS explained current CMS Pay for Performance P4P and the CDI responsibility under P4P explained some pertinent coding guidelines 2016 Official Coding Guidelines for Coding and Reporting AHIMA ACDIS practice brief for queries and compliance and much more I have no doubt in my mind that this book is a concise but a comprehensive tool and reference that anyone involved in CDI should always have at his/her side The Author Anthony O Nkwuaku RN PHN MSN CPHQ CCDS is very knowledgeable and experienced as a clinician clinical instructor and Clinical Documentation Improvement Specialist

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Clinical Documentation Reference Guide - First Edition AAPC, 2020-03-12 It's not the quantity of clinical documentation that matters it's the quality Is your clinical documentation improvement CDI program identifying your outliers Does your documentation capture the level of ICD 10 coding specificity required to achieve optimal

reimbursement Are you clear on how to fix your coding and documentation shortfalls Providing the most complete and accurate coding of diagnoses and site specific procedures will vastly improve your practice s bottom line Get the help you need with the Clinical Documentation Reference Guide This start to finish CDI primer covers medical necessity joint shared visits incident to billing preventative care visits the global surgical package complications and comorbidities and CDI for EMRs Learn the all important steps to ensure your records capture what your physicians perform during each encounter Benefit from methods to effectively communicate CDI concerns and protocols to your providers Leverage the practical and effective guidance in AAPC s Clinical Documentation Reference Guide to triumph over your toughest documentation challenges Prevent documentation deficiencies and keep your claims on track for optimal reimbursement Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra specificity specificity specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates and the pitfalls of auto populate features Master documentation in the EMR with guidelines and tips Conquer CDI time based coding for E M The Clinical Documentation Reference Guide is approved for use during the CDEO certification exam [Bridging the Gap Between Coding and Clinical Documentation Improvement \(CDI\)](#) Anneleah Williams Bridges,2020-02-14 Physicians play vital roles in the overall quality of patient care However HIM professionals and clinical documentation improvement specialists also share essential roles in the healthcare system as guardians of PHI and advocates for continuity of care through consistent documentation and accurate code assignment Clinical documentation improvement specialists CDIS are responsible for the communicative aspects of the process often serving as a liaison between the provider and the coder The CDIS ensures that the medical record is complete there is clinical validation to support diagnoses and that the medical record is consistent without conflicting or obscure documentation HIM professionals share some of the responsibility of CDIS in addition to abstracting data from the medical record and assigning the appropriate codes to accurately report the patient s clinical picture Without the two teams working hand in hand to improve the medical record s documentation billing errors could ensue and the quality of patient care is at risk The process is very detailed and requires a clinical and coding mind to work efficiently More organizations are calling for their CDIS to learn the fundamentals of coding and for their coders to review the medical record with clinical eyes Which is whythisresource proves invaluable Whether you re already skilled in HIM but want to add CDI expertise to your resume or an existing CDIS looking to update your coding skillset this publication will be of good use to you **Clinical Documentation Improvement (CDI) Made Easy, 2nd Edition** Anthony Nkwuaku,2018-02-24 The book provides clear guides on how to perform the vital duties required in obtaining accurate quality complete and specific documentation from the providers so as to reflect the quality of care severity of illness and risk of mortality of admitted patients during their encounter to the hospital or inpatient rehab The book is a must have for every

CDIS or anyone involved in clinical documentation The book has current ICD 10 CM PCS update with pertinent information on the 2018 Official Coding Guidelines for Coding and Reporting Coding Clinic advice Pay for Performance sample queries various disease processes by MDCs CDI strategy for success in inpatient rehab rehab impairment group codes and categories list of all the surgical and MS DRGs and much more Remember if it was not documented and documented accurately it never happened

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